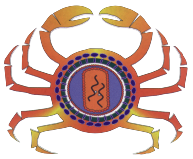
Sixth International Conference on Malignancies in AIDS and Other Immunodeficiencies: Basic, Epidemiologic and Clinical Research



The deadline for receipt of abstracts is February 11, 2002.

The National Cancer Institute is sponsoring the sixth conference on malignancies in AIDS and other immunodeficiencies. The objectives are to showcase progress and to stimulate research across diverse disciplines. The format will include invited lectures as well as oral and poster presentations of submitted abstracts. Topics will include the following:

Overview of Immune-deficiency Malignancies
- Congenital immune deficiency
- Epidemiology
- Infectious agents
- Pathogenesis
- Transplantation/therapeutic immune deficiency
- Tumor immunology

Kaposi's Sarcoma
- Epidemiology
- Role of human herpesviruses
- Pathogenesis
- Treatment

Tumor Virology - EBV, HPV, KSHV
- Mechanisms of virus latency, persistence, immune evasion and cell survival
- Virus transformation, oncogenesis and cell genetic changes
- Virus replication, vaccines and immunology

Hodgkin's and Non-Hodgkin's Lymphomas
- Epidemiology
- Role of human herpesviruses
- Immunology
- Molecular biology
- Treatment

Anogenital, Pediatric, and Other AIDS-associated Neoplasia

The detailed program from the 2001 International AIDS Malignancy Conference is available on the Internet at http://cancer.gov/dctd/aids/conference. The program for the 2002 Conference is presently being developed. As soon as it is available, it will be posted to that same Web page.

For information concerning program content, contact:

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For information concerning abstracts, registration, travel, lodging, etc., contact:

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ABSTRACT PREPARATION AND SUBMISSION GUIDELINES

General Instructions and Information

1. Please complete the information on the reverse side of the abstract form.
2. Individuals submitting abstracts may present only (1) abstract, but may be included as an author on other abstracts.
3. Abstracts will be reproduced in conference publications, as received.
4. Abstracts will be provided to all conference attendees. If you have patent or any other concerns about the wide distribution of your abstract, please modify your abstract accordingly prior to submission.
5. If your abstract is selected, audio or video recordings may be made of your presentation and copies made available to conference attendees. Your submission of an abstract constitutes your agreement that tapings can be made and tapes distributed.
6. The conference sponsor plans to offer Continuing Medical Education (CME) credits to attendees. Thus, upon selection, presenters will be asked to complete and sign a disclosure statement identifying any significant financial or other interest with the manufacturer, provider, or supporter of commercial products or services discussed in the presentation.

Abstract Preparation and Formatting

1. Email submissions are preferred. Please email your abstract as a Word or WordPerfect document with the following margins: 2.3" top, 2.07" bottom, 1.35" left, and 2.45" right.
2. Include the following information at the top of your abstract, in the following sequence: title of presentation, name(s), of author(s) with the name of the presenter underlined, and affiliations(s) of the author(s).
3. Your abstract should provide clear data and validated conclusions. It should consist of an introduction that presents background of the study, a brief description of the methods employed, a summary of the results, and a statement of the conclusions.
4. Do not include references or illustrations. A brief table, if typed within the abstract, is permitted. Abbreviations and acronyms other than "HIV," "AIDS," and other well- known AIDS terminology used in the abstract must be fully defined at the first mention.
5. Type abstract using single spacing.
6. Use a Times New Roman or Courier type style in a 12 point font size.
7. Print your abstract from a laser printer; do not use a dot matrix printer.
8. Type your abstract totally within the abstract frame; do not type on or outside the abstract frame. We cannot retype or accept for publication abstracts not confined to the format.

Abstract Submission

1. The deadline for abstract submission is February 11, 2002.
2. Do not submit your abstract via facsimile transmission.
3. Email your abstract to jquinn@mail.nih.gov or submit one (1) original and two (2) copies of your abstract to the address shown below:

   Jaime Quinn
   Division of Cancer Treatment and Diagnosis
   National Cancer Institute
   31 Center Drive MSC 2440
   Building 31/Room 3A44
   Bethesda, MD 20892-2440

4. Do not fold abstract forms. Mail them in a 9" x 12" envelope, with cardboard backing, or other packaging large enough to hold the full-size form.

DOSE-ADJUSTED EPOCH CHEMOTHERAPY (CT) IN PREVIOUSLY UNTREATED HIV-ASSOCIATED NON-HODGKIN S LYMPHOMA (HIV-NHL): PRELIMINARY REPORT OF EFFICACY, IMMUNE RECONSTITUTION, AND HIV CONTROL FOLLOWING THERAPY.

RF Little, D Pearson, G Franchini, S Steinberg, PE Elwood, R Yarchoan, and WH Wilson. National Cancer Institute, Bethesda, MD

CD4 depletion is a sequelae of both CT and HIV infection. Low-dose CT and antiretroviral therapy (ART) are given to minimize CD4 decline during treatment for HIV-NHL. However, in non-HIV-NHL, CT dose-intensity (DI) correlates with cure. Unknown pharmacokinetic and toxicity interactions with CT and ART may reduce DI and compromise cure. To maximize DI and minimize toxicity, we administered modified EPOCH (Wilson et al, JCO 11:1573, 1993) based on nadir counts, and suspended ART during the 16 treatment weeks in 23 pts with previously untreated HIV-NHL. ART was reinstituted immediately post-last CT infusion. Pt characteristics are: male=21 (91%); median (range) age=38 (31-49) and PS=1 (0-2); stage I=3 (13%), II/III=9 (39%), IV=11 (48%); B sx= 8 (35%); CD4<100/?l=8 (35%), LDH> normal= 17 (74%), and histology large B-cell=21 (91%) and small non-cleaved=2 (9%). With a median follow-up of 23 mos, median progression-free (PFS) and overall survival (OS) are not reached. At 2 yrs, actuarial PFS and OS are 82.6% and 72.4%, respectively. 16 (70%) have achieved CR, and there are no relapses. Toxicity was evaluable in 23 pts receiving 115 cycles. ANC and plt nadirs<500/?l and<50,000/?l, respectively, occurred on 29% and 16% of cycles; 12% of cycles had fever and neutropenia, 4% each had GI and N/V toxicity > grade 2, and neurotoxicity was rare. Average DI compared to full dose EPOCH was etoposide=93%, vincristine= 98%, doxorubicin= 96%, and cyclophosphamide= 56 %. CD4 and viral load were assessed at baseline and every 1-3 months thereafter. Of the 13 patients in CR with ?6 mos post-CT, median (range) baseline and last CT cycle CD4/mm^3 were 320 (42-474; n=13) and 150 (24-247; n=10), respectively. At ??24 weeks post-CT, the median CD4 was 303 (12-590; n=13) (p_2=0.92 baseline vs. ? 24 weeks). For the same pts, the median (range) baseline and last CT cycle $\log_{10}$ viral load =3.601 (2.30-5.86) and 4.47 (3.23-6.17), respectively. At ? 24 weeks post-CT, the median $\log_{10}$ viral load was 3.33 (2.30 - 4.79) (p_2>. 16 compared to baseline). These data suggest that temporary suspension of ART during CT does not prevent post-CT immune recovery or HIV control and allows administration of DI CT. Dose-adjusted EPOCH is well tolerated and highly effective when administered in this fashion.

SAMPLE ABSTRACT